Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

MEDICARE ELIGIBILITY STATEMENT

Wis. Stat. §§ 40.51 (7) and 40.52 (2)

Return form to the Department of Employee Trust Funds.

		Social Security Number
SUBSCRIBER NAME – *Policy Holder* (Last, First, Middle, Maiden)	SEX ☐ Female ☐ Male	Insurance Plan Name
ADDRESS (Street, City, State, Zip Code)		Group Number

TO CONTINUE COVERAGE THIS FORM MUST BE FILLED OUT COMPLETELY

1. In order to continue to be insured under the group health insurance program, you and/or your insured family members must be enrolled for both portions of Medicare (Hospital Part A and Medical Part B), when Medicare is first available as the primary insurer. Contact the Social Security Administration for information on how to enroll.

   Exception: You and your dependents are not required to be enrolled in Medicare until the subscriber terminates employment or health insurance coverage as an active employee ceases.
   You must inform ETF immediately if you or your spouse's Medicare Part B is dropped for any reason.

2. Indicate the reason Medicare is available:

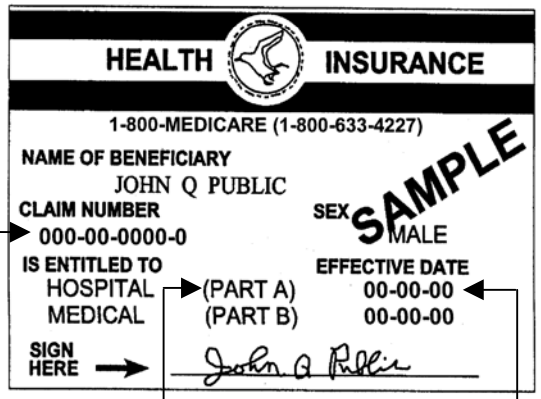
   ☐ a. Attainment of age 65 and over.

   ☐ b. Receipt of Social Security disability payments for 24 months.

   ☐ c. Permanent kidney failure.

3. List below all persons insured under your group health insurance policy. List Medicare effective dates as they appear on each person's Medicare I.D. card OR contact the Social Security Administration for effective dates. If not eligible for MEDICARE, enter "NOT ELIG." in Effective Dates columns.

4. Attach a photocopy of your Medicare Health Insurance Card or documentation from Medicare clearly stating your Medicare claim numbers and effective dates.



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NAMES	Birthdate (MM/DD/CCYY)	Claim Number	MEDICARE EFFECTIVE DATES *as shown on card*	
			Hospital (PART A)	**Medical (PART B)**
Subscriber				
Spouse				
Dependents				

Those who fail to enroll in federal MEDICARE must attach a written explanation to this form.

I authorize the Department of Employee Trust Funds to verify information from the Social Security Administration, if need be, regarding eligibility for effective dates of coverage under both Medicare Parts "A" and "B."

Date (MM/DD/CCYY)	**Signature**	**Daytime Telephone Number**

FOR ETF USE

Enrollment Type	Employee Type	Coverage Code	Carrier Suffix	Payroll Representative Signature	Telephone

Name of Employer	Employer Number	Group Number
	69-036-	

Make a copy for your records. Return the original copy to ETF.